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A Framework for School-Based Psychological Evaluations: Utilizing a ‘Trauma Lens’

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Abstract

Despite an increased recognition of the prevalence of exposure to traumatic stress in the lives of children, relatively little attention has been devoted to their socio-emotional functioning and learning experiences at school. This paper identifies a framework for trauma-informed psychological evaluation practices adapted to a school setting to facilitate the development of intervention strategies to account for trauma-related obstacles to learning. Specifically, the goals of the current paper include the following: (a) to provide a discussion of critical considerations or roadblocks that create challenges for the assessment of traumatized children at school; (b) to identify several primary functional domains in which children manifest trauma related difficulties at school; (c) to identify core issues that characterize each functional domain; and (d) to propose a general framework for evaluating these issues.

Key words: Trauma; children; evaluation; school; psychological evaluation; traumatic stress; trauma and learning; assessment; trauma assessment; school-based trauma assessment

A Framework for School-Based Psychological Evaluations: Utilizing a 'Trauma Lens'

The topic of childhood trauma has generated a surge of interest in recent years, fueled by an increasing recognition that traumatizing experiences during childhood are widespread both in the United States and throughout the world. Along with this growth in awareness is an ever-expanding understanding of trauma and a refinement in perspective. In general, professionals appreciate that a broad range of experiences can be extremely stressful for children, ranging from chronic conditions such as caregiver neglect to natural disasters and interpersonal violence. Numerous sources and methodologies have provided data on the high prevalence of childhood trauma, including retrospective accounts of adults, media accounts of massive systemic abuses (e.g., priest abuse cases), and school and community violence throughout the United States. Furthermore, societal awareness of trauma has increased following September 11th, 2001, the tsunami of 2004, Hurricane Katrina in 2005, the 2010 earthquake in Haiti, and other horrific events with global impact. Empirical research corroborates accounts of the widespread experience of significant adversity in childhood (e.g., see Costello, Erkanli, Fairbank, & Angold, 2002 and Felitti et al., 1998). The data indicate that many children are regularly confronted with threats to physical and emotional well-being. Sadly, we have ample evidence that interpersonal and family violence in particular are common in the lives of children in the United States today (United States Department of Health and Human Services, 2009).

School-based functioning is strongly impacted by traumatic exposure. Children manifest the consequences of trauma across developmental stages and across types of maltreatment. In early childhood, trauma impacts the building blocks that facilitate later successful school performance, including self-regulation and interpersonal relationships. Young maltreated children are rated as having lower frustration tolerance and more anger and non-compliance in

the preschool setting (Egeland, Sroufe, & Erickson, 1983; Vondra, Barnett, & Cicchetti, 1990), and lower persistence on, and greater avoidance of, challenging tasks in elementary school (Shonk & Cicchetti, 2001). Sexually abused adolescents are rated as lower in competence and higher in behavioral and social problems than same-age peers, and as more likely to be school avoidant (Daignault & Hebert, 2009; Trickett, McBride-Chang, & Putnam, 1994). Cognitive factors that support school performance are similarly impacted by early trauma: as compared with peers, maltreated preschoolers demonstrate lower flexibility and creativity in problem-solving (Egeland et al., 1983), while older children and adolescents with a history of abuse and violence exposure show impacted attention, abstract reasoning, and executive function skills (Beers & DeBellis, 2002).

Challenges with school performance and interactions translate into impaired school functioning: as compared with children who have not experienced trauma, children with these histories are more frequently referred for special education services and have a higher incidence of disciplinary referrals and suspensions (Eckenrode, Laird, & Doris, 1993; Shonk & Cicchetti, 2001). Such children frequently have lower grades, higher rates of academic failure, and lower scores on standardized testing at all grade levels (Eckenrode et al., 1993; Leiter & Johnson, 1994). Across studies, maltreated children are found to have significantly higher rates of grade retention and drop-out, with studies indicating as high as three times the drop-out rate for maltreated children, as compared with the general school population (Boden, Horwood, & Fergusson, 2007; Cahill, Kaminer, & Johnson, 1999; Eckenrode et al., 1993; Kurtz, Gaudin, Wodarski, & Howing, 1993; Leiter & Johnson, 1994).

Not only is school a place where the consequences of traumatic exposure are manifested, it is also an essential, potential contributor to a child's healing and coping. Prior psychological

literature has established the developmental importance of the environment to a child's well-being and adjustment, as well as the ongoing mutual transaction between a child and his or her ecology (Belsky, 1993; Bronfenbrenner, 1979; Freisthler, Merritt, & LaScala 2006; Lynch & Cicchetti, 1998; Zielinski & Bradshaw, 2006). This suggests that ecological factors can either buffer a child from the full effects of adversity, or conversely exacerbate a child's difficulties. Thus, evaluation and intervention with maltreated and traumatized children integrally includes attention to the surrounding settings in his or her life.

Despite an increased recognition of the prevalence of exposure to traumatic stress in the lives of children, the impact across domains of functioning, and the importance of ecology in buffering that impact, relatively little attention has been devoted to their socio-emotional functioning and learning experiences at school. Nevertheless, a number of authors have suggested that schools can play a significant role in the adjustment of traumatized children (e.g., Crooks, Scott, Wolfe, Chiodo, & Killip, 2007; Heller, Larrieu, D'Imperio, & Boris, 1999) and several efforts relevant to children at school have been disseminated recently. For instance, Horton and Cruise (2001) discussed symptoms that are often observed in maltreated children at school and discussed issues such as reporting suspected child maltreatment, school-based mental health services, and consulting with teachers and parents. Others (e.g., Dean, Langley, Kataoka, Jaycox, Wong, & Stein, 2008; Ngo, Langley, Kataoka, Nadeem, Escudero, & Stein 2008) have intervened on behalf of traumatized children using group therapy approaches at school based on a cognitive-behavioral paradigm. Saxe, Ellis, and Kaplow (2007) have advocated a model of assessment and treatment of trauma that involves intervening across levels of the child's ecology. They argued that a child cannot make effective change without involving the surrounding environment, an approach that is consistent with an ecological model of intervention. This

concept is integrated both into assessment and treatment, utilizing what they have termed the “Trauma Systems Therapy Approach.” Similarly, the Attachment, Self-Regulation, and Competency (ARC) framework (Blaustein & Kinniburgh, 2010; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005) emphasized that intervention must target both the child and the surrounding caregiving system; in this model, the caregiving system is broadly defined to include both immediate caregivers as well as contextual systems such as the school environment. Despite these important steps in the field, very little as of yet is written about evaluation models addressing trauma and its impacts on learning in a school setting. Even less is written about directly transforming the ecology of schools to be more sensitive to traumatized children (Greenwald O’Brien & Burnett, 2010a & 2010b).

The benefits of whole-school modalities of intervention such as trauma-informed evaluation, or trauma-informed school policies, may be seen in such exemplars as well balanced school disciplinary policies. Although establishment and maintenance of school safety is a critical goal, the over-application of “zero-tolerance” policies, for example, may lead to rigid and absolute disciplinary practices for even minor offenses. These practices mete out hard line consequences without nuance or an understanding of the behavior’s broader context or contributory factors. Consider, for instance, a young trauma-impacted child who has a difficult interaction with a peer during recess or other unstructured interaction. The influence of early experiences may be related to this child’s reluctance to seek adult support and guidance and an increased likelihood to perceive threat and behave aggressively – behavior that is, from the child’s perspective, self-protective and driven by a survival instinct.

Although whole-school approaches should not assume that trauma is playing a role in a child’s behavioral or academic performance, ideally these approaches will always consider

socio-emotional influences as one potential factor in both understanding and responding to student behaviors, performance, and needs. Evaluations should always include a process of differential diagnosis, with the perspective that sometimes behaviors associated with the sequelae of trauma can have a different etiology entirely, as when a basic neurobiological and/or developmental disorder explains a child's presentation without significant socio-emotional contributors. For example, certain seizure disorders can mimic dissociative responses, or Attention Deficit Hyperactivity Disorder can be related to dysregulated behavior at school, in the absence of any notable trauma history for a child. In other words, a child's difficulties at school can be unrelated to trauma, trauma can be a contributing factor, or trauma can account for most of the observed difficulties. Adopting a trauma lens can ensure that trauma is considered as a hypothesis when appropriate, but should not be used to overshadow other important etiologies for a child's presentation or lead to an over emphasis on trauma as an explanatory variable when other factors are more salient.

One recent initiative has attempted to interweave a trauma sensitive perspective into the fabric of the school-wide ecology. Specifically, Massachusetts Advocates for Children, in collaboration with the Hale and Dorr Legal Services Center of Harvard Law School and the Task Force on Children Affected by Domestic Violence, published a report and policy agenda entitled "Helping Traumatized Children Learn" (HTCL; Cole et al., 2005). In HTCL, the authors reviewed and synthesized empirical and theoretical literature relevant to trauma and learning for children, and set forth "The Flexible Framework" for schools and policy makers to facilitate the review and adoption of trauma-sensitive practices. HTCL was developed to address children affected by family violence, although many of the recommendations offered in the report could extend to children who have experienced any type of extreme and overwhelming stress. The

authors noted that the recommended trauma-sensitive practices for schools also provide benefits to the entire school (e.g., improved communication between school and home, teaching emotion regulation to students, increasing feelings of safety in the school). The Flexible Framework includes working closely with mental health professionals and addressing both the academic and non-academic needs of traumatized children, along with transforming the infrastructure and culture of the school to include trauma-sensitive pedagogical approaches, providing training and support to faculty and staff, and reviewing policy and procedure.

Cole et al. (2005) noted that traumatic responses can infiltrate many areas of critical functioning for children, including academic performance, the capacity to function within environmental expectations and demands (“behavior”), and relationships. As part of HTCL’s proposal for establishing school-wide environments that are supportive for traumatized children, they point out the need to create “guidelines for assessing students’ trauma-related educational, language and psycho-social needs” (p. 82).

This paper extends the work presented in HTCL by identifying a framework for trauma-informed psychological evaluation practices adapted to a school setting. The global purpose of such an evaluation is to understand the contribution and meaning of trauma in a child’s functioning at school. In so doing, the school can develop intervention strategies that will take into account trauma-related obstacles to learning. Specifically, the goals of the current paper include: (a) To provide a discussion of critical considerations or roadblocks that create challenges for the assessment of traumatized children at school; (b) To identify several primary functional domains in which children manifest trauma related difficulties at school; (c) To identify core psychological/behavioral issues that characterize each functional domain; and (d) to propose a general approach, or framework, for evaluating these issues.

An important premise of the current article is that in order to assist the school success of traumatized children, we must consider the hypothesis that trauma may be contributing to a child's functioning in the school setting. A second critical presupposition is that individual children's responses to trauma will vary and therefore each child who may be impacted by trauma will need a careful evaluation in order to understand his or her unique profile of skills and deficits. A third premise is that the child's unique learning history, post-traumatic or otherwise, will influence how he or she interacts within the current school context. We propose that, just as a school environment can buffer the effects of a challenging life and provide a safe and supportive haven for children, the school setting can also be a context that not only triggers traumatic reactions for children, but also reinforces some of the negative themes that have been learned over the course of a traumatized child's development, thereby increasing a child's vulnerabilities. For instance, a child with trauma experiences manifesting in low self-esteem who repeatedly experiences bullying by another child, or incurs hostile reactions on the part of teachers, will be at risk for adopting a self-assessment that he or she is unworthy of protection or a "bad" child, further lowering that child's confidence and motivation for success at school.

School Context: Critical Considerations

A developmental-ecological perspective would suggest that there is an inextricable mutual interaction between the child and setting, as children are both influenced by the setting in which they function (e.g., schools) and critically influence these settings as well. One need only contemplate the impact a bully can have on a child victim to appreciate the way children can shape (e.g., bullies), and be shaped by (e.g., the child victim), the school environment.

Schools represent unique environments with unique challenges. The school experience can nurture a child's innate abilities into full-fledged talents and competencies. However, school

personnel can also misinterpret the messages a child conveys through his or her behavior and inadvertently create obstacles to a child's success. Although the ensuing discussion is not meant to encompass the realm of all possible challenges encountered in school settings, we try to specify below some of the anticipated difficulties endemic to the problem of assessing and intervening with traumatized children in their natural school contexts, such as classrooms and recess (as opposed to traditional mental health services provided on site at school). Many of the points outlined below are complex and do not necessarily avail themselves to quick and simple solutions. However, we suggest that it is important for psychologists working within a school setting to be sensitive to these issues and address them as best fits the school milieu within which they are working.

Lack of Awareness of Trauma-related Information

Arguably, some of the most severe traumatic experiences of childhood, including aspects of family violence such as incest and witnessing domestic violence, may be unknown to any adults outside of the family. School personnel may have no confirmation of what is happening in the home. Parents and guardians may have concerns about sharing difficult and private child/family situations with school personnel for a variety of valid, as well as misapprehended, reasons. Witnessing violence, being a victim of incestuous sexual abuse, and other forms of family violence are common occurrences and have the potential to profoundly and detrimentally impact children, yet may not be immediately disclosed by children for any number of reasons. Some of these reasons, although debated, include developmental factors such as language immaturity associated with young age, cognitive delay and Pervasive Developmental Disorders. Other salient factors impeding a child from directly recruiting help may relate to psycho-social circumstances (e.g., financial dependence on perpetrator; fear of perpetrator, etc.) that create

obstacles to disclosure (see Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Paine & Hansen, 2002 for reviews related to delay of disclosure).

In school, a child may react to circumstances in ways that are perplexing and/or grossly unacceptable in the eyes of peers, teachers, and others in authority. Without awareness or hypotheses of a trauma history, professionals may not link the behavior to the possibility of trauma. Instead, children are at risk of being labeled with a range of behavioral characterizations and attributed with possibly irrelevant motivations for their maladaptive responses. For example, children are often attributed with laziness, lack of effort, or lack of cognitive capacity when trauma related avoidance behaviors influence disengagement with teachers and work production. In addition, a host of diagnoses may be contemplated (including those with symptoms most similar to those of childhood trauma), such as Attention Deficit Hyperactivity Disorder (ADHD), conduct disorder, bipolar disorder, Oppositional Defiant Disorder (ODD), anxiety disorders (aside from Post Traumatic Stress Disorder; PTSD), and depression, some of which may be applicable, without recognition of a possible trauma etiology.

Complexity of Student Needs

Teachers and other school personnel are confronted with a wide variety of children, each with a complex set of needs. It is difficult to completely understand and be sensitive to the requirements of a large group of classroom children simultaneously, whether traumatized or not. In some cases, teachers face entire classrooms of children with special challenges. For traumatized children, the specific manifestations of difficulties and the appropriate modifications needed are not necessarily readily identified in a standard special educational evaluation. Teachers and other school personnel need guidance and recommendations tailored to the needs of traumatized children in order to be equipped to help them optimally. Additionally, teachers

need support to adequately manage the overwhelming demands of educating this sometimes difficult population.

At times, even in the absence of a disclosure, a child's presentation or other information suggests to adults at school that he or she is being actively abused or neglected or is at significant risk of harm. In such a case, it is imperative to follow legal mandates to report concerns to state child protection agencies. Nevertheless, in the aftermath of such reports, the school often needs to discern a way to support the child and continue to work with the child's parents and/or guardians. Even after notifying the requisite agencies, schools typically need to work closely with the child in the sometimes traumatic period subsequent to maltreatment first coming to light. Additionally, school personnel may report suspicions of abuse or neglect that are not substantiated and the school may need information about how to help a child still perceived to be at significant risk by teachers and others.

Information Flow within Schools

Schools do not always have consistent policies for ensuring that sensitive information is treated with discretion. When a child makes a disclosure of personal information, there may be times when the information is disseminated in ways that can be embarrassing or shaming to a child or family, or can lead to negative perceptions or responses to the child and his/her family by school personnel. Without a clear sense of where disclosed information will be shared, parents might be understandably cautious about conveying information, even if it could be otherwise beneficial to a child for his or her private information to be communicated to a teacher or other responsible adult(s) at school. In the absence of assurance that information related to trauma would be handled with care and reasonable confidentiality, a child and family cannot be certain that the child will not be stigmatized, or that the information will not create further family

difficulties (e.g., concerns about involvement with child protection, or potential criminal or immigration proceedings). In other words, although it might provide significant benefit to a child to have his or her traumatic history known at school, unless the school's policies and protocols are clear, sensitive, and understood by parents, the potential negative repercussions might appear to outweigh the benefits for a family. Thus, it would be helpful to have school policies regarding confidentiality carefully outlined, as well as training of teachers and other school personnel about expectations for thoughtful and non-stigmatizing approaches to dissemination of psychosocial information.

School Safety

The school setting is sometimes the site of traumatic experiences and is not necessarily a safe haven for students. Schools may be perceived by students as increasingly less secure, especially in a time of heightened awareness of peer bullying and other school-related violence, corresponding with augmented media coverage of school and peer-involved aggression. However, the creation of safety (physical and psychological) is typically a recommended precursor to successful intervention for trauma. This suggests that it is critically important for schools to emphasize and support positive student-professional relationships in the building, implement strong and effective anti-bullying and anti-violence policies, limit harsh discipline or other policies that are potentially traumatizing, provide supports to teachers so that they can in turn be emotionally connected and supportive of their students, and implement effective and empirically based (to the extent available) violence prevention programs. In other words, it should be a priority to devote significant effort to creating a secure environment for all children.

Unrecognized Forms of Trauma

Certain forms of chronic childhood stress have yet to be widely recognized as potentially traumatic and may not be readily acknowledged in a school setting as placing a child at risk for traumatic stress reactions. However, as Streek-Fischer and van der Kolk (2000) noted:

Isolated traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma. In contrast, chronic childhood trauma interferes with the capacity to integrate sensory, emotional and cognitive information into a cohesive whole and sets the stage for unfocussed and irrelevant responses to subsequent stress. (p. 903)

A chronically neglected child may not be identified as traumatized in the absence of one or more discrete, concrete events (e.g., incident of sexual abuse or physical violence); yet, these children are frequently traumatized by unremitting life circumstances. Hildyard and Wolfe (2002) suggested that neglect in the absence of physical abuse may represent more severe isolation, less attention to the child, and less opportunity to develop language, cognitive, and social skills than the co-occurrence of neglect and other forms of maltreatment. Therefore, it will be important to recognize all forms of trauma to understand and reach out in a helpful way to the children in our schools who are struggling due to adverse and traumatizing life experiences.

Trauma-Informed Evaluation in the School Context

As noted above, identification of traumatized children at school can be difficult proposition. Children, especially those with family violence in their lives, do not generally announce themselves as victims of violence, and school teachers and personnel may have no idea that traumatic stress is contributing to school difficulties. In this situation, it is important that assessment practices be broad enough in scope to allow for social and emotional factors to emerge and trauma hypotheses to be explored. When intellectual and achievement tests alone

comprise the school evaluation, or even when simple symptom checklists are employed, these issues may be missed entirely. In other situations, the trauma has already been identified and psychologists will need to adopt assessment practices that facilitate an understanding of the child's mental health needs within the school setting, given the known traumatic experiences.

Requests for assessment of children's difficulties in schools take many forms and come with varied levels of formality. Although not technically a form of assessment, the least formal attempts arise in the form of informal teacher conversations with one another and with specialists in their buildings. This is often the first step taken to address a child's concerning progress or behaviors. Moving up the scale of formality, teachers may request consultation from social workers, psychologists, guidance counselors, speech pathologists, occupational therapists, or special educators. When a more formal venue is needed, teachers will often convene a "pre-referral" meeting (also known as a child study team meeting, an individualized support team meeting, etc.). These meetings include the teacher and any resource that may be able to assist the teacher in building an appropriate intervention plan, but do not legally require involvement of the parent or guardian. Finally, the most formal venue for addressing a child's difficulties is the special education Individualized Education Plan process, governed by panoply of laws and regulations. It is the contention of this paper that using a trauma lens to assess the child's difficulties has merit in all contexts, from the least to most formal.

The kinds of problems that teachers or parents bring to the attention of school-based evaluators stem from two basic issues: (a) The child is not adequately progressing through the curriculum; and (b) The child's external functioning is interfering both with his/her learning and with the daily operations of the classroom. Very rarely do assessment referrals include a request for an understanding of the impacts of known or suspected traumatic exposure. The questions

posed are those typical in a school setting: Are there cognitive reasons, diagnosable learning disabilities, or other diagnosable obstacles that impede the child from making more effective progress? If so, what can be done to remedy the situation? It becomes the purview of the psychologist or other evaluator to consider the role of trauma when building his or her hypotheses about the presenting problems, selecting assessment or testing methods, and interpreting the data gathered. We advocate that, to the extent possible, each evaluation of a child integrate some form of socio-emotional assessment, in recognition that symptoms can have multiple etiologies and can be multi-determined.

While considering trauma-informed evaluation within the school setting, it seems necessary to briefly address external, more formal “trauma evaluations.” There are several circumstances in which it is most appropriate to refer a child for evaluation of possible trauma outside of the school setting. First, when teachers and other school professionals have specific worries that a child’s difficulties are directly caused by ongoing abuse or neglect, including witnessing violence in the home, a mandated filing with child protective services is called for and assessment must occur beyond the school walls; nevertheless, even then teachers and others must devise a strategy to assist the child to function optimally at school. These are often the types of situations in which school psychologists and other specialists are called on to help teachers understand the child’s difficulties and support the most conducive environment in which a child can function.

On the other hand, school personnel may have concerns that a child has been traumatized but are without adequate information to know with any certainty. When these concerns coexist with significant problems in school, a comprehensive trauma evaluation may also be recruited from outside of school. In this case, the goal of a full trauma evaluation should be to identify

potential exposures, the kinds of impacts trauma may be having, and to yield information for school professionals that will help children adapt and function to the best extent possible.

Differentiating traumatic reactions from other disturbances in childhood can be difficult and challenging. In addition, seasoned and expert mental health professionals can disagree about whether the *recognition* of trauma is important for addressing the manifestations of trauma at school. In other words, some might assert that the symptomology of trauma can be adequately treated even without a full understanding of etiology. However, we would argue that: (a) it is not always transparent as to whether a history of exposure to traumatizing events underlies a child's behavioral/emotional problems at school; (b) a general school environment that has been developed to be sensitive to the needs of traumatized children will likely benefit children who are traumatized and those who are not, and (c) whenever possible, it remains an essential endeavor to attempt to comprehend the contribution of trauma (even if the specific details of traumatic experiences are not fully known) to a child's school-related struggles, so that the particular character of the problem is fully recognized. Perhaps most importantly, identification of trauma averts the misinterpretation of the origins of a child's problems, which can at times lead to the use of interventions (e.g., medication, treatment protocols geared toward managing other mental health disorders) that would not be appropriate for child whose difficulties are rooted in trauma exposure and response. Finally, accurate identification of trauma can facilitate interventions that, whenever possible, include caretakers and others in the child's life to create safety across environments and employ all available resources to help the child.

Our approach to assessment of children's school functioning suggests that utilizing a *trauma lens* within the context of a school-based evaluation may be most useful. In other words, we are not advocating that schools conduct a standard, clinical trauma evaluation, which may not

be appropriate in a school setting. Instead, we believe that incorporating a trauma lens and a flexible approach to evaluation would add an optimal (and realistic) component to better understanding and meeting the needs of children whose school-based difficulties are rooted in their trauma histories. In addition, we suggest that assessment will be most useful if it can be the precursor to targeted interventions designed to aid a child in the areas designated as problematic by the evaluation, and incorporate a strengths-based approach as well, to pinpoint areas of particular competence and gratification for a child.

Recognizing the importance of creating a structure and paradigm for assessing childhood trauma at school, the Trauma and Learning Policy Initiative (TLPI), an outgrowth of HTCL, convened a group of experts in several disciplines involved in the assessment of children in a school setting, including neuropsychologists, speech and language specialists, educators, child advocates, and psychologists with expertise in trauma. The TLPI group recommended that all professionals involved with the evaluation of children at school be versed in understanding trauma, so that results can be understood through a trauma-informed lens, when appropriate. This paper builds upon the work of this multi-disciplinary trauma evaluation group and provides the foundation for the psychological portion of their recommended framework (Massachusetts Advocates for Children, in preparation).

The ensuing discussion will focus on a proposed framework to guide school-based psychological evaluations of children, incorporating a trauma lens. Other areas for evaluation (neuropsychology, occupational therapy, speech and language, educational psychology, etc.) are equally important, albeit beyond the reach of this discussion. In particular, we encourage emphasis upon evaluating aspects of the school environment in order for an assessment to be complete and true to the developmental-ecological perspective espoused in this model.

Evaluation Domains and Core Issues

An outgrowth of the TLPI multi-disciplinary evaluation group was the recommendation of using the organizing framework of four functional domains to guide assessment practices at school (Massachusetts Advocates for Children, in preparation). Use of domains to guide assessment and intervention is consistent with other approaches to child trauma that increasingly emphasize core aspects of functioning rather than diagnostic profiles (i.e., Cook et al., 2005). Maltreated children may present with a wide range of diagnoses, including but not limited to PTSD (Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Margolin & Vickerman, 2007). Beyond specific diagnosis, there is general consensus that early trauma exposures frequently lead to profiles that include challenges with regulation of behavior, emotion, and cognition; impacted relationships; and shifts in competency across domains, including physical functioning and academic competency. Therefore, emphasis on core domains allows a broad “trauma lens” without restricting conceptualization to a single diagnostic category. As conceived, the domains overlap, meaning that deficits/strengths in one domain can also be an aspect of dysfunction and/or competence in one or more of the other domains. For instance, difficulty regulating emotion for a child (e.g., overreacting to social cues) can be an aspect of relationship dysfunction (e.g., inability to trust peers) as well.

Within each of these broad domains we have identified several “Core Issues,” defined as driving trauma-related reasons for an expressed behavior. As with the domains, some of the core issues may overlap. They are listed in Table 1, with discussion below of how they may be manifested in school. The Appendix provides a limited selection of examples of concrete, potentially trauma-related behaviors, as they may be observed in the school setting). It is important to note that many, if not all, of these behaviors and symptoms overlap with features of

other childhood diagnoses and issues; indeed, this is one of the challenges of assessing and treating trauma-impacted children, given the range of ways these children present and the lack of consensus on the most appropriate diagnostic conceptualization. The Appendix is therefore not intended to serve as a diagnostic frame or a “checklist” for identifying trauma, but rather as examples of ways these core domains may manifest in the school setting. Further, although the following discussion is meant to highlight and detail many of the primary expressions of trauma, we do not claim to include all possible manifestations of a child’s traumatic response. In addition, while these core issues can be used to identify areas of deficit, they can also be used to pinpoint strengths for traumatized children as well (i.e., areas in which children have relatively strong skills that can be built upon in planning at school). For instance, some children with trauma reactions may have relative strengths in certain academic areas or in peer relations, realms that are sometimes particularly challenging for children impacted by trauma. These relative strengths should become clear during trauma-informed assessment and will be important to take into account during treatment planning, which can optimally help bolster deficits and also build upon a child’s existing assets and abilities. Numerous authors have discussed the presentation of children with trauma, and we refer the reader to general summary articles articulating and substantiating some of the domain related findings discussed in this manuscript, such as Anda et al. (2006), Cook et al. (2005), Ford (2005), and Masten and Coatsworth (1998).

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Self- Regulation Domain

An impaired ability to self-regulate at a developmentally expected level is one of the most profound disruptions faced by many traumatized children, and is often considered to be at the heart of traumatic reactions (e.g., Ford, 2005; Kinniburgh et al., 2005). The increasing

capacity to self-regulate proceeds across developmental stages, and successful regulation is critical for school readiness and school success (e.g., Blair, 2002; Blair & Diamond, 2008). The following are descriptions of select core issues within the domain of self-regulation that may arise as a result of trauma exposure, and which are relevant to school success. For elaborated information regarding self-regulation difficulties encountered by traumatized children, see Cook et al (2005) and van der Kolk (2005).

1. Difficulty accurately identifying emotions/hyper-vigilance to threat. As compared with same-age peers, children who have experienced early trauma, and particularly interpersonal trauma such as abuse or neglect, may have difficulty accurately identifying their own internal emotional states, as well as in comprehending the emotions of others. Difficulties may include a lack of understanding or recognition of “emotion clues,” as well as an automatic – and self-protective - bias toward perceiving information as threatening. These children may misperceive neutral information as threatening, be quick to notice potential threats, and react strongly in the face of perceived or actual stimuli associated with traumatic experiences. In a school setting, such tendencies can be manifested in the following ways: (a) difficulty negotiating daily transitions, changes, or unstructured time periods. These represent situations of high ambiguity, in which unpredictability is maximized and therefore perceived threats may be highest; (b) frequent interpersonal conflict with peers and/or adults, sometimes characterized by seemingly inexplicable defensive hostility or withdrawal; or (c) heightened reactivity to perceived criticism, rejection, failure, or threat, both within and apart from academic classroom settings.

2. Impaired ability to modulate arousal. When children cannot accurately describe internal emotional experiences or recognize those of others, they then have difficulty choosing a proper response. They have trouble regulating their emotional and physiological reactions. This

core issue is often behaviorally reflected in school through the following: (a) inconsistent performance; edginess and distractibility in a classroom setting; (b) difficulty sustaining attention; (c) variable performance (across classes, tests, etc.); (d) emotional lability; (e) behavioral expression of internal arousal level, ranging from lethargic/disconnected to hyper-arousal/impulsive, exaggerated, disruptive, or destructive behavior; and/or (f) reliance on alternate coping strategies (i.e., compulsive behaviors; self-injury).

3. *Extreme mood states.* Because of difficulties with identifying and modulating affect, traumatized children are vulnerable to extreme mood states, such as depression, anxiety, and feelings of anger and rage. These can be exhibited in school in several ways, such as: (a) reduced motivation for task completion; (b) emotional interference in task completion; (c) emotion-oriented approaches to tasks (i.e., easily frustrated, difficulty with sustained problem-solving, all-or-nothing thinking, perceived failure, etc.); or (d) withdrawal from social relationships; and (e) angry outbursts and destructive behaviors directed toward objects or people.

4. *Dissociation/fragmentation.* Dissociation is a key survival coping skill in a traumatic situation; however, if it persists after the trauma it can lead to the disconnection of otherwise connected aspects of experience (e.g., an outside event and an emotional reaction, or an emotional reaction and the physiological expression of that state). Dissociation is often noted in the research and clinical literature as a common reaction to an overwhelming experience, particularly when that experience occurs early in life, is chronic, evokes extreme emotional states, and/or is inescapable. Among the primary manifestations of dissociation at school are: (a) alternating/inconsistent performance; (b) failure to attend to or comprehend class instruction (e.g., daydreaming); (c) denying known or observed behaviors, or lack of access to one's own

experience (appearing to lie); (d) disengagement from social structure; or (e) changeable presentation, or markedly different presentation at different times and with different people.

Case example. Madeleine is a 14 year old 8th grader known to have had extensive involvement with child protective services, although she continues to reside with her biological mother and siblings. She is considered very moody, and can go rapidly from calm to agitated to quite angry. She often overreacts to situations, and escalates far beyond what is warranted. Peers are put off because she is unpredictable, unpleasant, or even verbally aggressive. When agitated, her judgment is off and she misinterprets what teachers and peers say as more intrusive or threatening than intended. Using a trauma lens, evaluators attempted to understand Madeleine's moods in terms of dysregulation. They were able to understand her behavior as a way of communicating needs and expressing feelings that she did not know how to control. Evaluation led to increased understanding and empathy in staff, as well as the development of strategies designed to build an emotional vocabulary, teach recognition of internal states, and to help cue her when she was misinterpreting social signals (adapted from Greenwald O'Brien & Burnett, 2010b).

Physical Domain

This realm of function refers to a child's internal physiological reactions to trauma, as well as a child's external physical functioning in the world in response to trauma. The following issues highlight the common physical symptoms displayed by traumatized children at school.

1. Disconnection from body. By definition, dissociation can include psychological responses that disconnect the mind and body. Disconnection can relate to diminished self-awareness of place and/or time (disorientation) and diminished awareness and/or regulation of bodily functions and needs. These disconnections can contribute to an array of physical

symptoms that are especially impacted by a mind-body connection. Some of the manifestations at school may include: (a) enuresis; (b) encopresis; (c) accidental injury; (d) poor coordination and motor difficulties resulting in potential difficulties in physical education classes and sports; (e) poor hygiene and self-care, with inattention to appropriate dress; and (f) eating dysfunctions, including forgetting to eat and overeating.

2. *Physical holding of stress.* Traumatic responses can be manifested in pain and/or ailments that serve as nonverbal expressions of stress. Stress has been identified as impacting physical functioning in numerous deleterious ways, including through muscular, chemical, and immune system modifications. Possible manifestations at school include: (a) frequent visits to the nurse's office, absenteeism due to illness; coping through somatic expression (i.e., a traumatized child may express stress through physical means such as headaches or nausea, and may be more susceptible to illness); or (b) themes and/or preoccupations with illness, injury, or body image emerging in writing, art, or other aspects of school instruction.

3. *Physical integrity/boundaries.* A child who has experienced an actual or threatened violation of bodily integrity or witnessed the violation of another may experience an ongoing compromised sense of appropriate boundaries and physical integrity, manifested by: (a) rigid or intrusive physical boundaries with others (e.g., avoiding touch and physical closeness or alternatively, displaying inappropriate or intrusive affection); (b) sexualized behavior with other children; (c) self-stimulation (e.g., self-harming behaviors like cutting, self-directed sexual behaviors or sexually risky behaviors with others, and other risk taking behaviors such as substance abuse or delinquent activity).

4. *Trauma-related physical effects.* The direct consequences of trauma may involve physical injury associated with discrete traumatic events and/or neurological/physiological

impairments resulting from chronic neglect/trauma. Some of these physical effects that could impact school functioning include: (a) cutaneous injuries, burns, head and visceral injuries, and fractures; (b) failure to thrive; (c) sensory disabilities, such as hearing or vision loss (at times associated with inadequate care, such as a child with visual disabilities without eyeglasses); (d) frequent “accidental” injuries with implausible or insufficient explanations; and (e) developmental delays in any significant area of function.

Case example. Hannah is an 11 year old 5th grader who has been overweight since she started kindergarten. This combined with her poor hygiene and periodic enuresis in class has created social difficulties with peers. Her pediatrician can find no medical reason for her enuresis, which began after several years of good toileting control. She seems to have no awareness of the weather, and has come to school in tank tops in the winter. Teachers observe her to be increasingly clumsy, frequently knocking into furniture and other students. This results in minor injuries to Hannah, broken belongings of children in the classroom, and periodic episodes of disruption. Hannah does her schoolwork adequately when she does it, but often it seems impossible to get or keep her attention, and she produces little work.

With input from the school nurse and social worker, the teacher wondered whether Hannah was exposed to any inappropriate interpersonal experiences or other trauma. Hannah’s case was brought to the Child Study Team, and an initial screening assessment was conducted using behavioral and trauma checklists. This screening pointed to concerns about somatization and dissociation, prompting the team to speak in more depth about these issues with Hannah’s parents and to seek a trauma evaluation from an out-of-school provider.

Relationship Domain

Children who have been confronted with overwhelming circumstances, especially those of an interpersonal nature, very often experience a disrupted sense of self and ruptured personal relationships over time. This can extend to relationships both with peers and adults in a school setting. Troubled relationships contribute to difficulties with effective interventions in all the child's other areas of need. There are three primary core issues related to relationship troubles.

1. *Sense of self.* Traumatized children often endure a profound disruption in their sense of personal identity and a confused understanding of their own internal states (as noted above). At school, this can impact a child's ability to: (a) understand how his or her behavior affects others in the classroom, recess, or elsewhere at school; (b) utilize an awareness of the interrelationship between his or her own thoughts, feelings, behaviors, and body sensations to regulate interpersonal behavior appropriately; (c) label, communicate, and seek out educational and social needs; (d) feel and/or express empathy and sympathetic responses; and/or (e) develop or maintain a sense of confidence and competence.

2. *Trust and safety.* Depending on the form of trauma, many children experience tremendous challenges developing and sustaining comfortable, gratifying, stable, and trusting interpersonal bonds with peers or adults. This can be especially true for chronically traumatized children, who can experience early attachment disruption and a chronic lack of safety. This effect of trauma can be long-lasting, and at school can manifest in: (a) social isolation from others; (b) inability to bond with adults or peers at school; (c) inappropriate boundaries and facile attachments that leave a child vulnerable and open to further betrayal; (d) a tendency to interpret neutral cues as hostile/negative, and respond as if threatened, often with aggression or in some cases, withdrawal (noted above); (e) fear, distrust, and a pervasive, subjective feeling of danger; or (f) a tendency to push away potential sources of social, emotional, and academic supports.

3. *Social skills and competence.* A history of trauma is often associated with deficits in social skills, pragmatic language skills, social competence, and social problem-solving, impacting a child's relationship with individuals of all ages, but particularly with peers. The potential school-related manifestations of this difficulty are numerous, including: (a) peer social rejection; (b) frequent hostile interactions; (c) misreading social cues; (d) behavioral difficulties in contexts involving larger group peer interaction and/or unstructured components; (e) bullying and/or being bullied (replication of interpersonal violence dynamics); (f) school refusal and/or poor attendance; (g) avoidance of particular settings that are difficult to navigate (e.g., recess, gym) through various means, including exhibiting unacceptable behaviors in order to be "disciplined" and removed from challenging settings; (h) social withdrawal; (i) lack of basic pro-social skills; or (j) a tendency to be more comfortable interacting with younger peers.

Case example. Julio is a 13 year old 7th grader. His core team of teachers is comprised of both female and male teachers, but he experiences more difficulty with the male teachers. He alternates between being withdrawn and antagonistic in their classes. He is especially antagonistic when confronted with unexpected changes in routine or surprises in class and exhibits particular difficulties in interactions with Mr. Bird, his most creative teacher. Using a trauma lens to evaluate their concerns, his teachers had questions about past relationships and family variables that might interfere with his trust and safety. They spoke with Julio's mother regarding his difficulty with male teachers. She revealed that she and Julio had fled an abusive home. The teachers discerned that Mr. Bird's creativity was interpreted as unpredictability by Julio, and triggered his sense of danger. Based upon this information, the teachers developed strategies to help Julio manage his fears, including getting previews of Mr. Bird's material and

presentation plans and giving Julio extra time in a “safer” teacher’s classroom (a trusted, female teacher) when he was anxious (adapted from Greenwald O’Brien & Burnett, 2010b).

Academic Domain

Traumatized children often experience significant academic problems, sometimes related to the impact of the trauma directly (e.g., sequelae from traumatic brain injury, or cognitive delays secondary to childhood neglect), while other effects are most likely related to deleterious effects of chronic extreme levels of threat, fear, and stress. More and more, research is documenting some of the neurobiological impacts of child abuse and neglect (see Navalta, in press, for a comprehensive review) as well as the cognitive impacts often associated with children involved with child protective services (e.g., Mezzacappa, Kindlon, & Earls, 2001). In addition, the other problematic areas of function described above, such as dissociation or behavioral dysregulation, also interfere with an ability to learn. There are four primary core issues associated with the academic domain.

1. Information processing and language development. Traumatized children may have difficulty with narrative memory for events, accurate comprehension and interpretation of information, sequencing, organization, cause and effect relationships, and using language to communicate needs and to problem-solve. Some of the manifestations include: (a) difficulties following directions; (b) poor production (written, oral, homework, tests); (c) poor reading skills, including comprehension difficulty; (d) misunderstandings; (e) poor organization and study skills, and (f) auditory processing difficulties.

2. Executive functioning. Trauma-exposed children may show deficits in tasks that require goal-directed behavior and cognitive regulation, manifested by difficulty with: (a) sustaining attention and concentration; (b) working independently, shifting sets, dealing

w/interruptions, and checking mistakes; (c) starting or finishing work, remembering homework, and completing long term projects, compared with peers; (d) learning from feedback on performance; (e) written expression, writing essays, or figuring out math problems; (f) disruptive behaviors, controlling emotions, and self-inhibiting; (g) abstract reasoning and problem solving difficulties; (h) frustration intolerance; and (i) flexibility and adapting to new environments.

3. *Worldview and personal agency.* Traumatizing experiences often result in a sense of pessimism and danger, foreshortened future, and personal passivity linked to a perception of ineffectiveness. Many of these overlap with the Relationship Domain, but in this case specifically impact academic functioning, observed through: (a) lack of motivation or follow through; (b) angry, antagonistic, defensive perspectives; (c) helpless, lethargic, passive perspectives; (d) mental health symptoms, including depression and anxiety; (e) a sense of self as ineffective and/or worthless; and (f) early foreclosure of future possibilities or options.

4. *Learning disorders.* Traumatized children can have co-morbid but trauma-connected learning disorders (LD). An LD consists of below-expected performance (based on age, educational level, and IQ) in an academic area and interferes with academic achievement. This core issue can involve the LD's delineated in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) and therefore can involve any area of basic academic study. A frequent characteristic of a traumatized child's performance in challenging areas is variability and inconsistency over time. Speech and language idiosyncrasies can be reflective of diminished comprehension of human behavior and relationship and oddities of communication sometimes found in violent home (e.g., lack of communication about emotions). Reading and writing difficulties reflect the complex interplay of information processing, idiosyncratic comprehension styles, and the interpersonal aspects of learning to read and write.

Academic domain case example. Reggie is a nine year old 3rd grader with a known trauma history. He had global difficulties with school success, and was failing to make sufficient academic progress in most areas. Specifically, he had conceptual difficulties with both reading and writing, which impacted most content areas. He often “spaced out” during independent work, and was seldom able to complete tasks within the allotted time. However, he achieved at almost grade level in math and could complete some science activities when the instructions were provided orally. Using a trauma lens, Reggie’s in-school evaluation uncovered an anxiety-related emotional component to Reggie’s reading and writing challenges. Included in the recommendations was a suggestion that the teacher place Reggie’s desk near her work space, with an explanation that she would better be able to help him stay on task. She offered frequent non-verbal reassurances that she was there and available to him, and allowed him more time to complete assignments while maintaining high standards for his work. She created extra opportunities for him to demonstrate his math and science competencies, and used those arenas to bolster his reading and writing skills (adapted from Greenwald O’Brien & Burnett, 2010b).

General Considerations: School Based Psychological Evaluations

A primary intent of this paper is to help shift the standard practice of psychological evaluations in schools to one in which well-trained school psychologists can apply a trauma lens to their everyday work. Utilizing a trauma lens, school-based psychological evaluations: (a) consider multiple hypotheses, including those relating to trauma, regarding a child’s presentation and referral questions; (b) consider how the Domains and Core Issues relate to the questions posed in any evaluation; (c) choose assessment strategies based on the consideration of relevant Domains/Core Issues; and (d) interpret the assessment data with the trauma hypotheses in mind.

The current framework presumes that school-based clinicians have basic training and familiarity with child trauma, assessment options and practices, and/or access to consultation with others with such expertise, either within the school or in the local community. An extensive discussion of the details of best practices for clinical trauma assessment and evaluation is beyond the scope of this paper and is available elsewhere. The reader is referred to excellent discussions of this topic in other sources (e.g., Gil & Briere, 2006; Greenwald, 2005; Nader, 2008; Osofsky, 2004; Sax et al., 2007). In addition to the above, the framework described here presupposes that:

1. The mental health evaluator has a broad general education in behavior disorders of childhood and differential diagnosis.
2. As is consistent with general psychological assessment principles, the evaluator understands the importance of gathering information from multiple sources (e.g., several teachers and home) representing the multiple settings in which the child has been observed, as well as from the child whenever possible.
3. The evaluator employs multiple types of evaluation methods, not relying on a single method such as rating scales alone or interviews alone. This multi-source, multi-method approach should then incorporate the framework or the trauma lens proposed here.
4. The evaluator uses the current framework to determine the specific evaluation tools and focus appropriate for a given child within a school context.
5. The evaluator utilizes a flexible assessment approach, with the methods used dictated by a complexity of factors: the evaluators' background and experience with various approaches; expense and availability of resources; time and logistics; as well as the child's presenting problems and the specific referral questions. Additionally, a number of issues can be evaluated using the same methods, and most methods employed to evaluate

trauma yield information about other potential mental health problems. Importantly, a child can be impacted by trauma in addition to having other disorders, such as LD. As an example, if a child is referred for an evaluation because of a perceived lack of social interaction and isolation at school, the issue of trust and safety can be assessed by some or all the following methods: social perception and perspective taking measures administered directly to the child; observation of various social interactions at school (e.g., dyads and/or large groups in structured and/or unstructured settings); school based incident reports, and history of attachment and relationships difficulties, reported through interviews with the child's parent(s)/caregiver(s).

6. All of these issues should be evaluated, as indicated, within the framework of a larger evaluation team representing several different realms of specialization (e.g., education, speech, occupational therapy, etc.). Optimally all members of a team should have some knowledge of trauma or access to trauma-informed consultation, in addition to their broader professional areas of specialized training.

With this approach, we suggest organizing the assessment strategy and data obtained using the four domains outlined above: self-regulation, physical functioning, relationships, and academics. We believe that this approach will yield evaluations and recommendations with relevance for developing school-based interventions. The evaluator should first assess the strengths and difficulties in the domains and core issues relevant to the referral questions, as well as in other areas that emerge over the course of assessment. After a thorough assessment and clarification of a child's difficulties and strengths, the evaluator can provide recommendations about areas in need of intervention and areas for continued follow-up assessment using the domains as a framework. Toward that end, we suggest the use of a chart such as the one

depicted in Table 2, developed by members of TLPI and used with educational personnel and in educational settings (Ristuccia & Greenwald O'Brien, 2010). Such a chart recognizes the primary areas of traumatic response, as well as the need to employ intervention strategies within the different realms of a child's ecology. This type of graphic representation can be adapted for the needs of a specific the child. The number of columns could be increased to address all of the core areas relevant to this child. Finally, the chart can be utilized for areas of strength and competencies to be fostered, as well as for areas of deficit and challenge. As noted above, the domains of trauma-impact overlap substantially and intervention strategies often do not fit neatly into a "box." Instead, the point of this graphic organizer is to prompt evaluators to plan for the broad range of needs for traumatized children, and to recognize that interventions relegated to a small sector of school experiences likely will be less effective than integration of interventions across settings.

<<INSERT TABLE 2 HERE>>

Finally, with regard to crafting recommendations, we would like to stress the need to articulate both the rationale and purpose for each recommendation, and the specific ways the recommendation might be implemented. Psychological recommendations within the educational setting can seem similar across children (e.g. preferential seating near the teacher). A well-articulated rationale for recommendations and specific suggestions for implementation can help to foster school personnel motivation to follow through with crafting an appropriate plan. In addition, if the appropriate school staff (often the teacher) is unable to implement a recommendation as written, she or he will be more likely to develop modifications to meet the child's needs as closely as possible with a prior understanding of the original rationale. As an example, Teddy has difficulty trusting his teacher, overreacts to perceived slights by peers, and

has trouble staying on task independently. He may benefit by sitting in close proximity to the teacher during independent work periods, an intervention developed to facilitate attentiveness and work completion, with the expectation that he will progressively be able to move further from his teacher and continue to work at the same level. The rationale for this recommendation is that: (a) sitting close to the teacher serves as a frequent reminder that she or he is present, and builds a sense of security; and (b) it allows the teacher to use non-verbal signals to keep him on task, without stigmatizing him in front of the class. If the teacher is aware of the rationale for this intervention, she or he may become more generally attuned to Teddy's trauma-related issues, which can potentially have a positive influence on other, less formalized classroom interactions.

A difference between the current framework and a standard clinical trauma evaluation involves attending to the potential hazards of conducting an evaluation involving trauma history within a school setting. As discussed earlier, there are critical considerations related to conducting evaluations in school settings when there are potential (either known or unknown) histories of trauma. We believe that the flexibility and structure of our proposed framework allows for attending to the challenges and needs of traumatized (or suspected traumatized) children while also minimizing the potential "costs" that could occur if a standard clinical trauma evaluation were conducted and shared with school personnel. As noted above, utilizing the current framework should yield an evaluation with useful school-focused recommendations.

Additionally, employing a trauma lens within the current framework allows for the flexibility to hypothesize about potential trauma sequelae without the need to have knowledge of specific details of trauma exposure, in the cases in which such exploration is contraindicated. Although we believe it is best to understand the etiology of a child's difficulties, we acknowledge that in some instances it might not be perceived as in the best interest of a child or

family to have certain information revealed at school, nor is it always feasible. Instead, we anticipate that utilizing the proposed framework can allow for the generation and implementation of school-based interventions and recommendations, even when there is only a suspected trauma history. In addition, we hope that creating a framework of shared understanding about child trauma will serve to facilitate sensitive and child-centered practices regarding dissemination of trauma-related information within the school context.

Of note, there are circumstances in which it may not be possible for a school to proceed with an evaluation of a potentially traumatized child, even utilizing the more flexible approach advocated in the current framework. These circumstances include situations during which a child may be experiencing ongoing maltreatment or trauma. Sometimes schools do not have confirmation of current abuse, but suspicions may have been generated based on any number of indices, including severe and disturbing behaviors exhibited by a child. When a child is experiencing ongoing maltreatment or other potential interpersonal trauma, he or she most likely will not respond positively to school-focused interventions until his or her physical and psychological safety is assured. In cases in which concerns of current abuse have been generated, abuse and trauma interviews and/or evaluations are often most appropriate, using clinically and forensically sound assessment methods that require specialized training. These assessments are categorically different from the assessments described in this paper and should not be conducted at school; referrals should instead be made to outside experts, and only following expert evaluation, follow-up assessment regarding school-functioning can proceed. In some situations, when mandates require contacting state child protection agencies, such assessments can only be properly arranged in conjunction with the agency.

Conclusions

We perceive many advantages to using the organizing framework presented here, informed by the trauma literature, to prepare and interpret assessments in a school setting. First, an awareness of trauma as a hypothesis expands the repertoire of choices when considering methods of evaluation. Second, the language of the four domains can have the advantage of facilitating a shared understanding among school and trauma professionals. Third, the domains and core issues should help prevent the tendency to assume that certain behaviors (e.g., hyperactivity) can only be viewed in terms of certain diagnostic conditions (e.g., ADHD vs. traumatic dysregulation). Fourth, the domains lend themselves to formulation and concrete recommendations relevant to the manifestations of trauma.

Most adults, including teachers, are motivated to help children do their very best. We are all limited when intentions to assist are hampered by inadequate assessment information. This can lead to the squandering of resources, as well as precious time in a child's life, on misdirected approaches to intervention and planning at school. To advance the success of school children, we hope to combine background knowledge on the effects of traumatic stress in children with the sophistication in assessment practices associated with psychology practice. Our goal is for all children to have the opportunity to thrive, especially those who have had the misfortune to struggle with significant adversity.

References

- Ackerman, P. T., Newton, J. E. O., McPherson, W. B., Jones, J. G., & Dykman, R. A. (1998). Prevalence of post traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse & Neglect*, 22(8), 759-774
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (Revised 4th ed.). Washington, DC: Author.
- Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174-186.
- Beers, S., & DeBellis, M. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *American Journal of Psychiatry*, 159, 483-486.
- Belsky, J. (1993). Etiology of child maltreatment: A developmental-ecological analysis. *Psychological Bulletin*, 114(3), 413-434.
- Blair, C. (2002). School readiness: Integrating cognition and emotion in a neurobiological conceptualization of children's functioning at school entry. *American Psychologist*, 57(2), 111-127.
- Blair, C., & Diamond, A. (2008). Biological processes in prevention and intervention: The promotion of self-regulation as a means of preventing school failure. *Development and Psychopathology*, 20, 899-911.

- Blaustein, M., & Kinniburgh, K. (2010). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency*. New York: Guilford Press.
- Boden, J. M., Horwood, L. J., & Fergusson, D. M. (2007). Exposure to childhood sexual and physical abuse and subsequent educational achievement outcomes. *Child Abuse & Neglect, 31*, 1101-1114
- Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. *American Psychologist, 34*(10), 844-850.
- Cahill, L., Kaminer, R., & Johnson, P. (1999). Developmental, cognitive, and behavioral sequelae of child abuse. *Child & Adolescent Psychiatric Clinics of North America, 8*, 827-843.
- Cole, S., Greenwald O'Brien, J., Gadd, M. G., Ristuccia, J., Wallace, D. L., & Gregory, M. (2005). *Helping traumatized children learn*. Boston, MA.: Massachusetts Advocates for Children.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., ... van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390-398.
- Costello, E. J., Erkanli, A., Fairbank, J. A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress, 15*(2), 99-112.
- Crooks, C. V., Scott, K. L., Wolfe, D. A., Chiodo, D., & Killip, S. (2007). Understanding the link between childhood maltreatment and violent delinquency: What do schools have to add? *Child Maltreatment, 12*(3), 269-280.

- Daignault, I. V., & Hebert, M. (2009). Profiles of school adaptation: Social, behavioral and academic functioning in sexually abused girls. *Child Abuse & Neglect, 33*, 102-115.
- Dean, K. L., Langley, A. K., Kataoka, S. H., Jaycox, L. H., Wong, M., & Stein, B. D. (2008). School-based disaster mental health services: Clinical, policy and community challenges. *Professional Psychology: Research and Practice, 39*, 52-57.
- Eckenrode, J., Laird, M., & Doris, J. (1993). School performance and disciplinary problems among abused and neglected children. *Developmental Psychology, 29*, 53-62.
- Egeland, B., Sroufe, A., & Erickson, M. (1983). The developmental consequences of different patterns of maltreatment. *Child Abuse & Neglect, 7*, 459-469.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*, 245-258.
- Ford, J. (2005). Treatment implications of altered affect regulation and information processing following child maltreatment. *Psychiatric Annals, 35*(5), 410-441.
- Freisthler, B., Merritt, D. H., & LaScala, E. A. (2006). Understanding the ecology of child maltreatment: A review of the literature and directions for future research. *Child Maltreatment, 11*(3), 263-280.
- Gil, E., & Briere, J. (2006). *Helping abused and traumatized children: Integrating directive and nondirective approaches*. New York: Guilford Press.
- Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P. H., & Gordon, D. S. (2003). Why children tell: A model of children's disclosure of sexual abuse. *Child Abuse & Neglect, 27*(5), 525-540.

- Greenwald, R. (2005). *Child trauma handbook: A guide for helping trauma-exposed children and adolescents*. New York: Haworth Press.
- Greenwald O'Brien, J. P., & Burnett, L. (Eds.). (2010a). Unpublished manuscript. *Building a school environment to support the development of self-regulation skills*. Framingham, MA: Framingham Public School System, MA.
- Greenwald O'Brien, J. P., & Burnett, L. (Eds.). (2010b). *Strategies guide for working with children exposed to trauma*. Framingham, MA: Framingham Public Schools.
- Heller, S. S., Larrieu, J. A., D'Imperio, R., & Boris, N. W. (1999). Research on resilience to child maltreatment: Empirical considerations. *Child Abuse & Neglect, 23*(4), 321-338.
- Hildyard, K. L., & Wolfe, D. A. (2002). Child neglect: Developmental issues and outcomes. *Child Abuse & Neglect, 26*(6-7), 679-695
- Horton, C. B., & Cruise, T. K. (2001). *Child abuse & neglect: The school's response*. New York: The Guilford Press.
- Kinniburgh, K., Blaustein, M., Spinazzola, J., & van der Kolk, B. (2005). Attachment, self-regulation, and competency: A comprehensive intervention framework for children with complex trauma. *Psychiatric Annals, 35*(5), 424-430.
- Kurtz, P., Gaudin, J., Wodarski, J., & Howing, P. (1993). Maltreatment and the school-aged child: School performance consequences. *Child Abuse and Neglect, vol 17*, 581-589.
- Leiter, J., & Johnson, M. (1994). Child maltreatment and school performance. *American Journal of Education, 102*, 154-189.
- Lynch, M., & Cicchetti, D. (1998). An ecological-transactional analysis of children and contexts: The longitudinal interplay among child maltreatment, community violence, and children's symptomatology. *Development and Psychopathology, 10*, 235-257.

- Margolin, G., & Vickerman, K. (2007). Posttraumatic stress in children and adolescents exposed to family violence: I. Overview and issues. *Professional Psychology, Research and Practice, 38*, 613-619.
- Massachusetts Advocates for Children. (2010). *Helping traumatized children learn: Volume II*. Manuscript in preparation.
- Masten, A., & Coatsworth, J. (1998). The development of competence in favorable and unfavorable environments: Lessons from research in successful children. *American Psychologist, 53*, 205-220.
- Mezzacappa, E., Kindlon, D., & Earls, F. (2001). Child abuse and performance task assessments of executive functions in boys. *Journal of Child Psychology and Psychiatry, 42*(8), 1041-1048.
- Nader, K. (2008). *Understanding and assessing trauma in children and adolescents: Measures, methods, and youth in context*. New York: Routledge.
- Navalta, C. P. (in press). Neuropsychological aspects of child abuse and neglect. In A. S. Davis (Ed.), *Handbook of pediatric neuropsychology*. New York, NY: Springer.
- Ngo, V, Langley, A, Kataoka, S. H., Nadeem, E., Escudero, P., & Stein, B. D. (2008). Providing evidence-based practice to ethnically diverse youth: Examples from the cognitive behavioral intervention for trauma in schools (CBITS) program. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(8), 858-862.
- Osofsky, J., Ed. (2004). *Young children and trauma: intervention and treatment*. New York: Guilford Press.
- Paine, M. L., & Hansen, D. J. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*(2), 271-295.

- Ristuccia, J & Obrien, J.G, & Trauma and Learning Policy Initiative (2010). *Personal Communication*.
- Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach*. New York: Guilford Press.
- Shonk, S.M. & Cicchetti, D. (2001). Maltreatment, competency deficits, and risk for academic and behavioral maladjustment. *Developmental Psychology*, 37, 3-17.
- Streeck-Fischer, A., & van der Kolk, B. (2000). Down will come baby, cradle and all: Diagnostic and therapeutic implications of chronic trauma on child development. *Australian and New Zealand Journal of Psychiatry*, 34(6), 903-918.
- Trickett, P., McBride-Chang, C., & Putnam, F. (1994). The classroom performance and behavior of sexually abused females. *Development & Psychopathology*, 6, 183-194.
- United States Department of Health and Human Services, Administration on Children, Youth and Families. (2009). *Child maltreatment 2007*. Washington, DC: U.S. Government Printing Office.
- van der Kolk, B. A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5), 401-408.
- Vondra, J., Barnett, D., & Cicchetti, D. (1990). Self-concept, motivation, and competence among preschoolers from maltreating and comparison families. *Child Abuse & Neglect*, 14, 525-540.
- Zielinski, D. S., & Bradshaw, C. P. (2006). Ecological influences on the sequelae of child maltreatment: A review of the literature. *Child Maltreatment*, 11(1), 49-62.

Table 1

Domains and associated core issues

<u>DOMAINS</u>	<u>CORES ISSUES</u>
<i>Self Regulation</i>	Deficits in emotion identification Hyper-vigilance to threat Impaired ability to modulate arousal Extreme mood states Dissociation
<i>Physical Functioning</i>	Disconnection from body Physical holding of stress Physical Integrity/boundaries Trauma-related injuries
<i>Relationships</i>	Sense of self Trust and safety Social skills and competence
<i>Academics</i>	Information processing Language development Executive functioning World view and personal agency Learning disorder

Table 2

Student Planning Matrix

	Classroom	Specialists (e.g., SW, guidance, speech,)	Schoolwide Culture (e.g., Policies, Adminstration)	Unstructured Settings (e.g., Recess, Schoolbus)	Family (e.g., home- school communication)
Relationships					
Academic & Non- Academic Success					
Self- Regulation					
Physical & Mental Well Being					

Appendix

Brief Examples of Child/Adolescent Traumatic Responses at School, by Domain

Domain 1: Self-Regulation**1A. Impaired Affect Identification/ Hypervigilance to Threat:**

- Vigilance to evaluator expression; observed lability or sudden mood changes,
- Inconsistency in standardized test patterns within/across measures of same ability
- Reports of sudden shifts in mood
- Abrupt loss of motivation/withdrawal in face of perceived failure

1B. Impaired Ability to Modulate Arousal

- Observation of “ADHD”-like behaviors, or consistent/inconsistent low arousal
- Physical attempts to modulate arousal (fidgeting, shifting in seat)
- Impulsive responding (talking out of turn, jumping up)
- Low levels of arousal (“spacing out”, daydreaming)
- Reports of “feeling bored”, trouble concentrating

1C. Extreme Mood States

- Observed anxiety: fidgeting, frequent need for reassurance, clinginess with teachers / caregivers, “freezing” in class or on tests
- Test patterns, in academic classroom tests, or during standardized testing, that shift depending on child’s emotional state at time of testing
- Overall depressed academic or test performance, discrepant from known cognitive ability
- Child report of feeling sad, irritable, anxious, angry

1D. Dissociation/Fragmentation

- Glazed/dazed appearance
- Sudden or unexpected shifts in mood state; sudden shift from hyperarousal to constriction
- Markedly different personality across time, situation, and person
- Inconsistent test performance within/across measures of same ability

Domain 2: Physical Functioning**2A. Disconnection From Body**

- History of enuresis or encopresis, especially if secondary and physical etiology is ruled out
- History of poor coordination, poor hygiene, weight issues, or other symptoms without medical or other etiology
- Observation of poor motor coordination

2B. Physical Holding of Stress

- History of frequent somatic complaints
- History of frequent visits to nurse’s office, sick days, colds, flu
- Themes/preoccupation of illness/injury, body image during projective testing

2C. Physical Integrity/Boundaries

- History/observation of sexualized behaviors
- History/observations of inappropriate physical boundaries
- Limited response to re-direction or “teaching” of appropriate boundaries; repetitive compulsion to engage in behaviors
- Poor peer relationships and limited social skills

2D. Trauma-Related Injuries

- History of both neglect and developmental delays
- History/medical records of specific injuries procured during traumatic event
- Reports of developmental delays (e.g., speech/language, neuropsychological, academic evaluations)

Domain 3: Relationships

3A. Sense of Self

- Difficulty labeling internal states and emotions in self and others
- Unrealistically low scores on self-report, psychosocial measures such as behavior rating scales
- Behavioral observation of negative reactions to challenges during testing, including negative self-statements, loss of motivation in the face of perceived failure etc.

3B. Trust and Safety

- History of attachment and relationship difficulties
- Incident or other reports indicating physical or verbal altercations with peers or adults
- Peer isolation

3C. Social Skills and Competence

- Observed difficulty or distress during unstructured time (i.e., recess, lunch)
- Reports of bullying or rejection by peers, or by child toward peers
- Difficulty completing tasks requiring social perspective-taking or problem-solving

Domain 4: Academic Success

4A. Information Processing and Language Development

- Difficulty following directions at home, in the classroom, and/or in the evaluation situation
- Difficulty with verbal response and expression, particularly in response to open-ended questions
- Difficulty organizing coherent written or verbal narratives

4B. Executive Functioning

- Observer reports of socially inappropriate behaviors, with little self-awareness. Difficulty by child in organizational strategies required to complete tasks which are at the child’s level of cognitive/academic capacity
- Observations or testing indicating challenges with working memory, attention, planning and organizing, processing speed, complex problem solving

4C. Worldview and Personal Agency

- Child self statements indicating lack of confidence (e.g., “I can’t”)
- Passivity in task initiative and social interactions
- Defiance/hostility toward teachers/peers
- Avoidance of tasks

4D. Learning Disorders

- Academic achievement which is discrepant from measured cognitive ability
- Achievement deficits which are insufficiently explained by intellectual and socio-emotional contributions